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Cancer Registry Review

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ACR ANNOUNCEMENTS

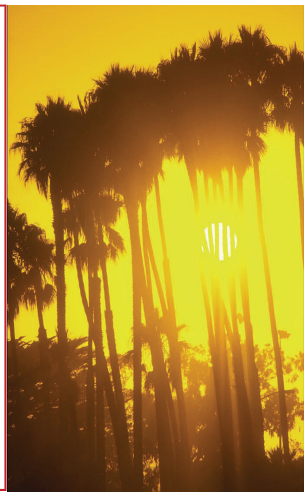
DOCTORS' OFFICES IMPORTANT TO COMPLETE REPORTING

The ACR recently mailed an informational packet on cancer reporting to dermatologists, dermato-pathologists, urologists, medical and radiation oncologists, and hematologists/oncologists. Information from physicians' offices is important to the goal of a complete registry because cancer patients are increasingly being diagnosed and treated in outpatient settings . Arizona law requires physicians to submit a report to the ACR for those patients whose disease was not diagnosed in a licensed pathology laboratory and who are not referred to a hospital or clinic for first course of treatment.

ACR staff currently review the reports from private pathology laboratories and then seek confirmatory information from patients' physicians. If physicians fail to reply, these pathology-only cases cannot be included in incidence counts because pathology reports lack sufficient demographic information. The "Path Labs" slices in the pie charts below illustrate that this type of incomplete case reporting represents a not insignificant percentage of skin melanoma and prostate cancer cases reported in 2002 and 2003.

(Physicians, continued on next page)

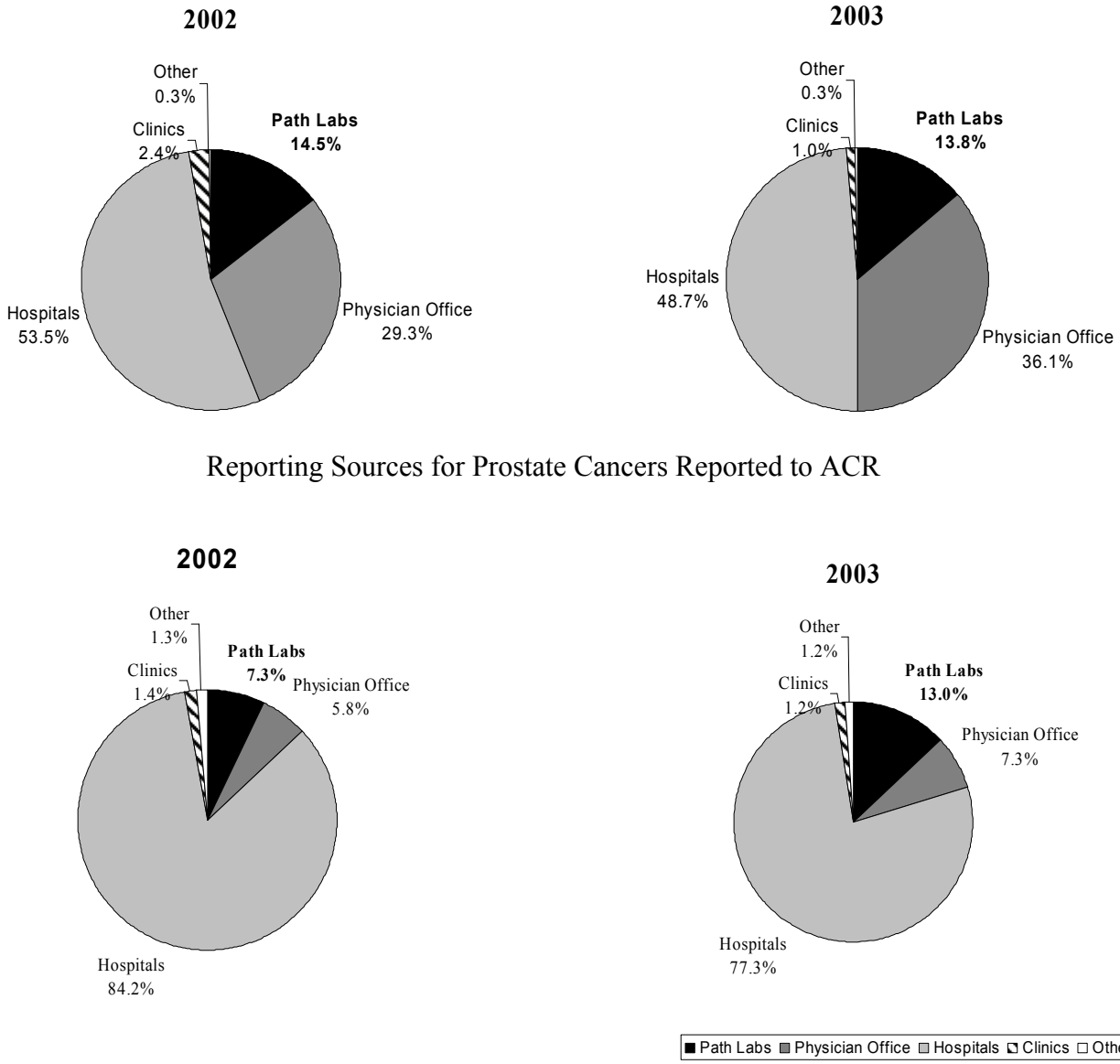
In This Issue of Cancer Registry Review



ACR ANNOUNCEMENTS

(Physicians, continued from previous page)

Reporting Sources for Skin Melanomas Reported to ACR



Reporting Sources for Prostate Cancers Reported to ACR

NEW MEMBER OF ACR TEAM

Carmen Williams
Cancer Data Specialist

Carmen was born and raised in St. Louis, MO, and has been living in Phoenix since January 1997. She moved here because of the pleasant winters. Carmen is a recent Phoenix College graduate, with an Associate of Applied Science degree in Health Information Technology, and will sit for the national exam in the very near future. Carmen's passion is quilting but she also enjoys reading, walking, art, and a nice cool breeze. She is very excited to be a part of the ACR.

ACR ANNOUNCEMENTS

NAACCR Completes Review of 2003 ACR Data

NAACCR Review of 2003 ACR Data

The North American Association of Central Cancer Registries (NAACCR) annually reviews state and provincial data to evaluate quality, completeness, and timeliness. NAACCR uses six evaluation measures. Each has a gold or silver standard (no bronze) for level of compliance. To be NAACCR-certified, a registry must meet gold or silver standards for all six criteria.

The ACR did not achieve certification for year 2003 data (the most recent year for evaluation) because of lower-than expected completeness of case ascertainment. Arizona achieved gold standard on the other five measures. See the table below for detailed results. Below the table is a brief explanation of each performance measure.

(NAACCR, continued on page 5)

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ACR ANNOUNCEMENTS

Errors in ICD Revision Numbers and Cause of Death Codes

Some registrars are finding an error (**ICD Revision Number, Cause of Death - SEER IF37 or ICD Revision, Vital Stat, Date Last Contact-NPCR)** when they run edits that check for correct values for: 1) ICD Revision Number, 2) Cause of Death (COD) code, and 3) Relationship between the ICD Revision Number and Cause of Death codes. If the code entered for either field is invalid, or the relationship between them is incorrect, an error will be generated. The years for which each ICD revision number is used has been set by NAACCR and determines the COD codes that must be used. Registrars must use ICD-9 codes for deaths occurring in the years 1978 – 1999. Either ICD-9 or ICD-10 codes can be used for 1999 deaths (In Arizona it is ICD-9). Deaths from the year 2000 and later are coded using ICD-10.

When a COD code is incorrect, an error will be generated. Examples of COD code errors are:

- An incorrect ICD-9 code of "1850" is entered instead of "1859" OR
- An incorrect ICD-10 code of "C610" is entered instead of "C619"

For RMCDS users, the ICD revision number is system-generated in the software program and cannot be changed. The codes generated are: (0) alive, (1) ICD–10, and (9) ICD 9.

An example of an incorrect pairing of the ICD Revision Number and Cause of Death Code would be entering an ICD revision number of "1" (ICD-10) and a COD code of "1859" (ICD-9); the correct COD code should be "C619," which is from ICD-10.

Due to coding formats, periodically the COD codes were entered incorrectly and then sent to facilities. An attempt to clean up incorrect COD codes was made ten years ago and lists of changes to be made to the COD codes were sent to facilities. In most instances, the incorrect COD code has a '0' in the 4th position instead of a '9'. The ACR cannot send a new backup with the correct codes to RMCDS users. RMCDS programs will only overwrite the COD code if the field is blank or populated with zeroes. Facilities using software vendors other than RMCDS may have incorrect codes in the COD field as well.

In order to correct these errors, facility registrars will need to access the cases and change the COD codes. The ACR will create a list of cases by facility that have an incorrect COD code. Each case on the list will need the COD code corrected to the one on the list.

Facility registrars also have the option of changing the COD code to "7777", the generic unknown COD code. However, using this alternative will cause the precise COD code to be lost.

Registrars who use RMCDS may mass change the incorrect codes to "7777" by using the "Hand Pick" option in the Subset menu to create the subset, and then choosing "Mass change data items" under the Modifications menu to change the COD code to "7777" for all cases in that subset.

Please keep in mind that we will only be sending lists of cases that presently have an incorrect COD code in the ACR's database. If the COD code was changed at the ACR but never changed at the facility, it will not be on our list and so you may have additional errors in your database that we do not have.

If you have any other questions about the correction process you may call Chris Newton at 602-542-7324, or email him at: newtonc@azdhs.gov.

(NAACCR, continued from page 3)

Registry Element	Gold Standard	Silver Standard	Actual Measure*	Measurement Error Allowed	Standard Achieved
Completeness of case ascertainment	95%	90%	86.5%	1.0%	Not achieved
Completeness of information recorded					
• Missing/unknown "age at diagnosis"	<=2%	<=3%	0.0%	-0.4%	Gold
• Missing/unknown "sex"	<=2%	<=3%	0.0%	-0.4%	Gold
• Missing/unknown "race"	<=3%	<=5%	2.1%	-0.4%	Gold
• Missing/unknown "State/Province & county"	<=2%	<=3%	0.2%	-0.4%	Gold
Death certificate only cases	<=3%	<=5%	2.4%	-0.4%	Gold
Duplicate primary cases	<=1 per 1000	<=2 per 1000	0.5 per 1000	-0.4 per 1000	Gold
Passing EDITS	100%	97%	100%	N/A	Gold
Timeliness *Data submitted within 23 months of close of accession year*	N/A	N/A	N/A	N/A	Gold

Completeness of Case Ascertainment

Completeness of case ascertainment is gauged using a two-step process. First, national incidence and mortality rates are applied to Arizona's mortality rate in order to estimate the expected incidence rate. This expected rate is then compared to the observed incidence rate. Arizona was not certified for year 2003 data due to the shortfall on this criterion.

Completeness of Information Recorded

The data items age at diagnosis, sex, race, and state and county of residence at diagnosis are critical to a state registry's central objective of generating incidence rates. Therefore, the percentage of unknown values for these items needs to be kept to a minimum.

Death Certificate Only (DCO) Cases

The percentage of death certificate only cases is one measure of data completeness. Death records with cancer listed as a cause of death are compared against the registry's database. ACR staff members attempt to collect information from doctors and hospitals on those cases that are not in the registry. If no further information can be gathered, the case is added to the registry as a DCO.

Duplicate Primary Cases

Because several facilities may be involved in a patient's care, the ACR often receives more than one abstract for the same case. One function of the Operations Section is to consolidate multiple reports into a single record. The presence of too many duplicates results in overcounting cases.

OTHER NEWS– NCRA HIGHLIGHTS

Melanoma Primer

April Fritz, RHIT, CTR, gave a presentation at NCRA titled "Messy Malignant Melanomas Made More Meaningful." Her talk cleared up sources of confusion that seem to go with the territory when abstracting melanoma cases. A few helpful highlights:

Single vs. Multiple Primary Melanomas

Unless stated to be a recurrent or metastatic melanoma, record each melanoma as a separate primary when any of the following criteria are met:

The occurrences are at least two months apart

OR

The third numeric digit of the ICD-O topography code for skin (C44.__) is different

OR

The first three digits of the ICD-O morphology code are different.

Effective with cases diagnosed January 1, 1997 and later, if an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis. (***Note:*** The purpose of this guideline is to ensure that the case is counted as an incident case (i.e., invasive) when incidence data are analyzed.) (From SEER Program Coding and Staging Manual 2004, Fourth Edition).

Histology

Lentigo Maligna (8742/2)

- Non-invasive lesion
- Not stageable using the AJCC system
- AJCC-related Collaborative Staging fields map to 88 codes (Not Applicable)*
- Lentigo maligna is a precursor lesion to Lentigo Maligna Melanoma

* Note- Please remember that histology exclusions do not apply to Collaborative Staging. If a particular histology cannot be staged using an AJCC schema, 88 codes will be generated for the T, N, and M fields. If you enter a histology that is not listed in the AJCC Cancer Staging Manual, Sixth Edition you do not get an edit. Errors only are generated when the values are entered incorrectly.

Lentigo Maligna Melanoma (8742/3)

- Long pre-invasive (radial) growth phase
- Usually occur on the faces of elderly patients
- AJCC stageable, unlike Lentigo Maligna

Regressing Melanoma

There is a morphology called "Regressing melanoma" (8723/3), but only assign this code if this is the histology stated in the **final diagnosis section of the pathology report. This issue was addressed in SINQ #20051103 (Full text below)**

References

1. 2004 SEER Manual ;pgs C-432 (App C, July 2003)
2. ICD-O-3

Question

CS Extension/Histology--Melanoma: When does the term "regression" affect the coding of melanoma cases? Please see discussion.

Discussion

For melanoma, many path reports document the presence or absence of regression. At what point does the presence of regression become significant enough to code it for histology and for CS Extension?

Example 1: Skin biopsy showed malignant melanoma, Breslow thickness 0.38 mm, Clark's level II, ulceration is absent, regression is present.
Example 2: Punch biopsy showed malignant melanoma, Clark's level II, 0.34-mm maximum depth of invasion,

(Melanoma, continued on next page)

OTHER NEWS– NCRA HIGHLIGHTS

(Melanoma, continued from previous page)
with apparent regression.
Example 3: Skin biopsy showed lentigo maligna undergoing regression.

Answer
Regression does not affect CS staging for cutaneous melanoma. "Malignant melanoma, regressing" [8723] is coded only when it is the final diagnosis. Do not use code 8723 for the examples above.

According to our pathologist consultant:
Melanoma can occasionally undergo "spontaneous" regression -- the tumor can become smaller, and in some cases even disappear. This phenomenon is likely due to an increased immune response on the part of the "host" (person with the melanoma). This is noted occasionally in patients with metastatic disease which gets smaller, or even disappears. We think this is also what has happened in patients who get diagnosed with metastatic melanoma, say in a lymph node, but have no primary tumor, though sometimes give a history of a skin lesion which came and then went away, or a skin lesion which was not submitted for pathological examination. In addition, we (pathologists) occasionally see biopsies which have melanoma as well as the presence of the immune reaction to it, and once in a while, the immune reaction with little or no evidence of residual melanoma.

The College of American Pathologists says that regression of 75% or more of the melanoma carries an adverse prognosis.

Collaborative Staging

Regression

Do not code CS Extension to "99" for a melanoma in regression if information about depth of invasion exists. The presence of regression may result in under staging, but using whatever information is available is preferable to assigning an unknown stage.

Clark vs. Breslow

Both of these systems, used to describe depth of invasion, are used in Collaborative Staging.

Clark- Expressed in terms of "levels". Each level indicates a dermal layer. For instance:

Clark's level II- Papillary Dermis
Clark's level V- Subcutaneous tissue

Clark's level is used in the data item CS Extension.

Breslow- Expressed as millimeters from skin surface. Even though Breslow's is expressed in millimeters, code as hundredths of millimeters. For instance,

0.74 mm thick= 074
2.93 mm thick= 293
1.02 cm thick= 989 (9.89 mm or thicker)

Breslow's is captured in Site Specific Factor 1.

Satellite Lesions or Metastasis vs. In-Transit Metastasis

The CS Lymph Nodes field takes into consideration not only the presence or absence of regional lymph node involvement, but the presence of either satellite lesions or in-transit metastasis:

Satellite Lesion or Metastasis- Grossly evident metastatic skin lesion within the immediate vicinity (usually within 2 cm) of a primary malignant tumor. Located in the dermis or subcutaneous tissue.

In-Transit Metastasis- Metastasis found in lymphatic channel.

CS Lymph Nodes Eval

If no regional lymph nodes are removed, but satellite nodule(s) or in-transit metastasis is biopsied, use codes indicating a pathologic staging basis (i.e., "2" or "3").

CODING CORNER

QUICK LIST OF HEMATOPOIETIC DISEASES

This list is not meant to be comprehensive- Synonyms for many of the disorders listed here can be found in the "Abstracting and Coding Guide for the Hematopoietic Diseases" (AKA "Red Book")

Disease	Reportable?
Acute differentiated progressive histiocytosis	Yes
Acute infantile reticuloendotheliosis	Yes
Acute panmyelosis with myelofibrosis	Yes
Acute progressive histiocytosis X	Yes
Acute reticulosis of infancy	Yes
Angiocentric immunoproliferative lesion	No
Angioimmunoblastic lymphadenopathy with dysproteinemia	No
Aplastic anemia	No
Chemotherapeutic atypia	No
Chronic myeloproliferative disease	Yes
Dendritic cell sarcoma, Follicular	Yes
Dendritic cell sarcoma, Interdigitating	Yes
Eosinophilia, NOS	No
Eosinophilic granuloma, solitary/multifocal	No
Essential thrombocythemia	Yes
Fanconi's anemia	No
Graft versus Host disease	No
Hand Schuller Christian disease	No
Heavy chain disease	Yes
Hemophagocytic lymphohistiocytosis	No
Hemophagocytic syndrome	No
Histiocytic sarcoma	Yes
Histiocytosis X, NOS	No
Hypereosinophilic syndrome	Yes
Hypochromic anemia with iron loading	No
Immunoblastic lymphadenopathy	No
Immunoglobulin deposition disease, i.e., • Primary amyloidosis • Systemic light chain disease	No
Immunoproliferative disease	Yes
Immunoproliferative small intestinal disease	Yes
Iron-deficiency anemia	No
Langerhans cell granulomatosis	No
Langerhans cell histiocytosis, generalized/disseminated/progressive	Yes
Langerhans cell histiocytosis, NOS/unifocal/ Mono-ostotic/multifocal/poly-ostotic	No

Site-Specific Issues

Melanoma

Surgical Coding of Melanoma (ACoS I&R #18441)

Electrocautery was used to stop bleeding with an excisional biopsy (path taken). The electrocautery was not used to remove, control, modify or destroy cancer tissue. Would the Surgical Procedure code be 22 (Local tumor excision, NOS with electrocautery) or 27 (Excisional biopsy)?

Reply

This would be coded as 22, Local tumor excision, NOS with electrocautery. FORDS page(s) 268 was used as the resolution source.

Clinically Occult vs. Clinically Apparent Lymph Nodes

Page 211 of the AJCC Cancer Staging Manual (Melanoma of the Skin chapter), differentiates between "clinically occult" and "clinically apparent" nodal metastasis. Patients without clinical or radiologic evidence of lymph node metastases, but who have pathologically documented nodal metastases, are defined by convention as exhibiting "microscopic" or "clinically occult" nodal metastases. Patients with clinical or radiologic evidence of nodal metastases and a pathologic examination documenting the number of nodal metastases (after therapeutic lymphadenectomy) are defined by convention as having "macroscopic" or "clinically apparent" nodal metastases."

Site-Specific Factor 3 (Clinical Status of Lymph Node Mets) Melanoma of the Skin

Site-specific factor 3 refers to nodes defined as positive through conventional H&E staining methods. It does not include IHC methods.

Prostate

Geographic Distribution of Prostate Cancer Versus Tumor Bulk (ACoS I&R #18373)

Path report from the prostatectomy specimen showed, "A few small microscopic foci identified in the apex, mid portion, and base of the right lobe." Clinical extension was 15 (Tumor identified by needle biopsy, e.g., for an elevated PSA). I&R 7916 talks about the distinction between T2a (Unilateral, one-half of one lobe or less) and T2b (Unilateral, involving more than one-half of lobe but not both lobes), stating the designation is for geographic distribution in the prostate and not the total tumor bulk.

Do we interpret a few small foci as less than 1/2 a lobe or more than 1/2 a lobe, because it is in the apex, mid and base of the right lobe? The physician staged this T2a.

Reply

We recommend this be coded as pT2b. We are clearly aware of discrepancies between the clinical and pathologic T category definitions. Many T1c cases are pT2b.

General Issues

Date of First Contact (JRM, Spring 2006)

The Spring, 2006 edition of the Journal of Registry Management contained clarifications of the Date of First Contact field. These clarifications covered three scenarios:

1). If a patient is admitted to hospital for a diagnosis other than malignancy and is found to have cancer during the hospital stay, then the date of first contact would be the same as the date of diagnosis, not the same as the

(Coding, continued on next page)

CODING CORNER

(Coding, continued from previous page)

date of inpatient admission. Some software providers have created an edit that the Date of First Contact cannot precede the Date of Diagnosis. The following two examples are from the ACoS I & R:

12695
8/29/2004

FORDS

If a patient came to our facility 2/03/04 with a complaint of abdominal pain and an exploratory lap was performed 2/05/04 and a diagnosis of colon cancer was made, what is the date of first contact?

Updated 3/14/06: The date of first contact is the date the patient was seen at the reporting facility for diagnosis and/or treatment of cancer. The date of first contact would be 2/5/04.

10215
12/17/2003

FORDS

If a patient was admitted 2/28/03, diagnosed 3/4 and discharged 3/5, what is Date of 1st Contact?

If the patient was admitted for a suspected cancer or for diagnostic tests, the Date of First Contact is the date of admission. If they were admitted for other reasons, use the diagnosis date.

This is a clarification and not a change; therefore, there is no effective date for registrars to begin following this rule if they had not been doing so. The change is effective immediately.

2). A class of case 7 becomes reportable if that patient presents to the facility for cancer-related work-up or treatment. In that case, the date of first contact is the date the patient presented to the hospital for work-up and/or treatment, not the date the outside pathology specimen was read by the hospital's lab.

3). If a patient was diagnosed at a staff physician's office and comes to the facility for all or part of first course of treatment, the date of first contact is the date the patient physically presented at the facility with a cancer diagnosis. This rule applies despite the fact that a staff physician's office is considered to be an extension of the facility and the class of case would be 1.

Isolated Tumor Cells

Isolated Tumor Cells (ITC's) are single cells or tiny clusters of cells, measuring in aggregate 0.2 mm or less. They are usually detected using immunohistochemistry (IHC) or molecular methods. Cases with ITC's in regional lymph nodes should be classified as N0.

ITC's are discussed in depth in breast cancer staging schemas, but they apply to all sites. Please refer to page 5 of the AJCC Cancer Staging Manual, 6th edition.

New or Updated Coding References

Registry Plus Online Help

Registry Plus Online Help (RPOH) is a handy one-step reference center that can reduce your need to haul around heavy coding manuals. Included on RPOH are full text versions of: Collaborative Staging Manual and Coding Instructions, FORDS 2004, The SEER Program Coding and Staging Manual, 2004, NAACCR Data Standards and Data Dictionary, 10th ed., Record Layout 11 (Cross-referenced with FORDS 2004 and SEER Program Coding and Staging Manual, 2004).

Also included are the introductory section and numeric lists from the ICD-O, and selected material from the SEER Program Code Manual, 3rd Ed., 1998 and ROADS. You can download RPOH to your desktop by going to http://www.cdc.gov/cancer/registryplus/rpoh.htm and following the instructions.

Collaborative Staging Reference for "Unknown" and "Not Applicable" Codes

There has been some confusion surrounding the appropriate "unknown" and "not applicable" codes for Collaborative Staging items. The codes used vary from schema to schema. An Excel spreadsheet listing these codes for each schema is now available at http://www.cancerstaging.org/cstage/index.html. The document was posted on 4/26/06 and is titled Default and unknown values for CS items (80K XLS Excel format). Distinctions between these codes are especially important to central registry staff when abstracting death-certificate only cases, but hospital registrars may find this reference helpful as a "cheat sheet" and to verify that everyone is coding consistently.

New Opportunities to Earn CE's from the Commission on Cancer

The Commission on Cancer recently introduced their Online Education Center, available at http://www.facs.org/cancer/index.html. The Online Education Center provides "webinars" for a fee. Webinar topics are most relevant to registrars at facilities that are CoC approved or are seeking approval, but in the future the CoC plans on adding some topics, such as Collaborative Staging, that are pertinent to all registries.

Presentations cost $30 each for staff at CoC-approved hospitals, and $50 for staff working in programs not approved by the CoC. Most sessions award 1.25 CE's to CTR- credentialed participants.

NPCR Webinar Series

The National Program of Cancer Registries (NPCR) sponsored a series of "How to Collect High Quality Cancer Surveillance Data" webinars covering Colon, Prostate, Breast and Lung primaries in late 2005 and early 2006. Each session covers site, histology, treatment, and Collaborative Staging coding. These webinars are now available online. The live sessions carried CE credit, but currently the posted ones do not. Nonetheless, they provide a good review for experienced registrars, and are particularly useful for new staff members.

To access the presentations, go to the NAACCR home page, http://www.naaccr.org/. On the left side of the home page is a bar with links to various sections of the site. Click on "Education & Training," then select the "Training Modules Online" link.

You need to have a WebEx media player installed on your computer before you can access the presentations. WebEx can be downloaded from the NAACCR web site, from a link that is right above the links to the individual webinars.

A new series of webinars will be starting in October. The ACR has purchased subscriptions for three locations in Arizona in an effort to keep costs to facilities at a minimum and to maximize participation. The following facilities will be hosting the upcoming series:

ACR	Phoenix
Northwestern Medical Center	Tucson
Flagstaff Medical Center	Flagstaff

Registrars can attend the sessions at the nearest host facility free of charge. The tentative schedule is:

10/12/06	Abstracting Head and Neck Cancer Incidence and Treatment Data
12/14/2006	Abstracting CNS Tumor Incidence and Treatment Data
1/11/07	Abstracting Urinary System Cancer Incidence and Treatment Data
2/8/07	Abstracting Lymphoma Cancer Incidence and Treatment Data
3/8/07	Abstracting Colon and Rectum Cancer Incidence and Treatment Data
5/10/07	Abstracting Prostate Cancer Incidence and Treatment Data
6/14/07	Abstracting Lung Cancer Incidence and Treatment Data
9/13/07	Abstracting Breast Cancer Incidence and Treatment Data

COMING SOON

Revised Commission on Cancer Program Standards

The Commission on Cancer's Cancer Program Standards 2004: Revised Edition was issued in March. Changes to the manual reflect the addition of three program categories: Veteran's Administration facility, Pediatric, and Pediatric Cancer Program Component programs. A Pediatric program provides services solely to a pediatric population. A facility in the Pediatric Cancer Program Component category accessions at least 50 newly diagnosed pediatric cases a year. The two pediatric programs' requirements differ from the other categories in the collection of follow-up and AJCC stage information. Pediatric patients are excluded from follow-up calculations once they reach the age of 27 years, but the standards do suggest that follow-up efforts continue. Additionally, the AJCC staging requirement does not apply to pediatric patients. Information from pediatric cancer staging systems should be recorded in the appropriate text fields.

Changes to AJCC Cancer Staging Manual, 6th Edition

Updates to the sixth edition of the TNM staging manual were issued in mid-2003. These changes were not widely publicized, and so registrars may or may not have been made aware of them at the time of their publication. Many updates are clerical in nature, but there were several substantive changes.

Detailed information about any changes registrars need to make to their facilities' databases will be forthcoming from the ACR.

A document listing all of the modifications can be found at http://www.cancerstaging.org/products/ajccproducts.html . A link near the top of the page titled "Summary List of Clarifications to AJCC Cancer Staging Manual, 6th edition" will bring you to the Adobe document. Additionally, the manual's publisher issued replacement pages for the major changes. These can be obtained at www.cancerstaging.net. Please note that replacement pages were issued only for the major changes and that clerical changes will need to be hand-written into your manual. The major changes include:

Schema-specific Histology Listings

Formerly, if a case's histology was not listed, it could not be staged using that particular AJCC classification. The histology lists in each chapter have been under review, and so this rule was updated to state that the histology lists are to be used as a guide in determining which cases to stage using the AJCC classification. If a histology in question is not listed, please consult the ACoS I & R. If an item in the I & R database does not address your particular concern, submit a question to the I & R.

Lip and Oral Cavity Schema

A lip tumor invading through cortical bone, inferior alveolar nerve, floor of mouth, or skin of face, i.e., chin or nose, is considered to be T4a. Previously, lesions meeting these criteria were erroneously categorized as T4.

Soft Tissue

Stage groupings I and II were subdivided into IA and IB and IIA and IIB.

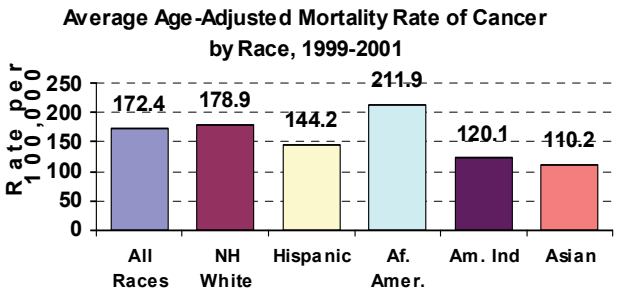
Retinoblastoma

The N2 category was removed from clinical TNM classifications.

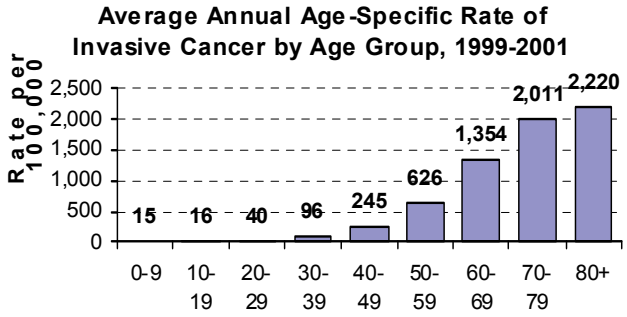
DATA SECTION

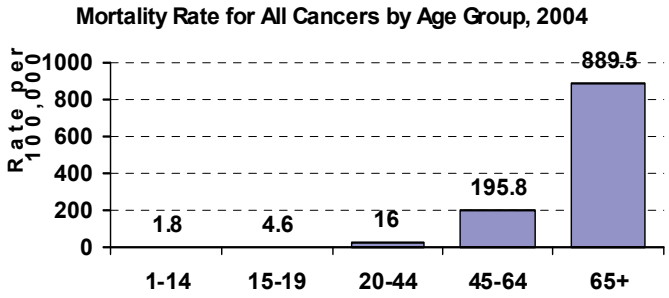
Your Data Hard at Work!

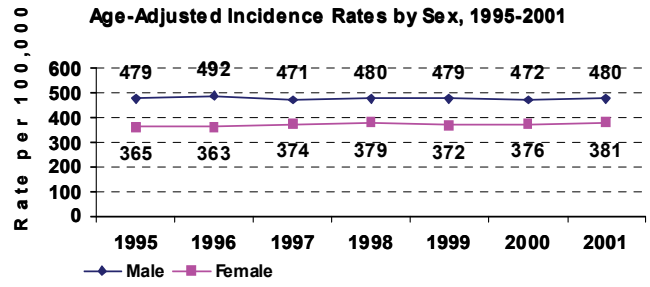
Cancer is the second leading cause of death in Arizona. In 2004, 9,504 Arizonans died from cancer. This is approximately 22 percent of all deaths. The Arizona Cancer Registry records an average of 23,678 new cancer cases every year; the most common types of cancer are lung, colorectal, female breast, and prostate. Epidemiologists broadly look at age, sex, race and ethnicity, and geographic location to detect significant differences in the rates of diseases. These differences are often referred to as health disparities. Health disparities are defined as key differences in: Incidence (number of new cases), mortality (number of deaths), prevalence (number of existing cases), and the burden of disease that exists among specific populations. A striking example of a cancer disparity is African American's higher overall cancer mortality rate compared to other racial and ethnic groups.

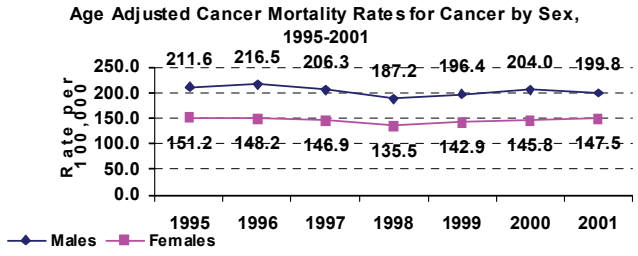


Older populations have much higher rates of incidence and death compared to younger populations. Men also have higher rates of incidence and death compared to females, largely because males have a longer history of tobacco use than females.









Cancer incidence rates were highest for Mohave,

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DATA SECTION

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Maricopa, Yavapai, Gila, and Coconino counties. Cancer mortality rates were highest for Gila, Greenlee, Yavapai, Mohave, and Graham counties. The higher mortality rates in Gila, Yavapai, and Mohave counties were compatible with their higher incidence rates.

Average Annual Age-Adjusted Rates of Cancer by County, 1999-2001

Incidence			Mortality	
Place	**Rate**		**Place**	**Rate**
Mohave	445.3		Gila	209.8
Maricopa	434.8		Greenlee	201.9
Yavapai	433.3		Yavapai	196.4
Gila	423.6		Mohave	194.6
Coconino	421.2		Graham	188.8
Pima	417.3		Maricopa	177.2
Cochise	405.4		Pima	174.2
Graham	401.9		Cochise	173.5
Greenlee	376.0		Pinal	161.0
Pinal	361.6		Santa Cruz	160.8
Santa Cruz	348.8		Navajo	155.6
Navajo	329.4		Coconino	138.3
Yuma	323.9		Apache	120.0
La Paz	316.2		Yuma	119.6
Apache	187.4		La Paz	103.5
Arizona	419.2		Arizona	172.4

One method of classifying the extent of cancer is called cancer staging. SEER Summary Staging groups cancer into five main categories: *in situ*, localized, regional, distant, and unknown. *In situ* refers to an early cancer that is present only in the layer of cells where the tumor began. Localized describes a cancer limited to the organ of origin. Regional means the cancer has spread beyond the primary site to the nearby lymph nodes, organs, and/or tissues. Distant describes a cancer that has spread beyond the primary site to the distant lymph nodes and/or distant organs. Unknown is used when there is not enough information to assign a stage. The majority of cases are diagnosed at the early stage (*in situ* or local). However, when specific sites, for example colorectal cancer, are analyzed separately the majority of cases are diagnosed in the late stage (regional or distant). Another striking example of a health disparity is the somewhat later stage diagnosis of colorectal cancer among American Indian, African American, and Hispanic populations compared to Non-Hispanic White and Asian populations. Nonetheless, there is room to decrease the percentage of late stage diagnosis among all racial and ethnic groups.

Percentage of All Cancer Cases by SEER Summary Stage and Race/Ethnicity, 1999-2001

Race/Ethnicity	Early	Late	Unknown
NH White	48%	34%	18%
Hispanic	39%	41%	19%
African American	38%	45%	17%
American Indian	37%	42%	22%
Asian	46%	38%	16%
All Races	46%	35%	18%

Percentage of Colorectal Cancer Cases by SEER Summary Stage and Race/Ethnicity, 1999-2001

Race/Ethnicity	Early	Late	Unknown
NH White	39%	49%	12%
Hispanic	34%	54%	12%
African American	30%	55%	15%
American Indian	22%	61%	17%
Asian	46%	40%	15%
All Races	38%	50%	13%

Lastly, the Arizona Cancer Registry collaborates with the ADHS Comprehensive Cancer Control program's health disparities subcommittee. This committee is actively addressing the issue of cancer disparities.

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DATA SECTION

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References

ADHS. Arizona Health Status and Vital Statistics 2004. Arizona Department of Health Services. State of Arizona. November 2005. Available at http://www.azdhs.gov/plan/report/ahs/ahs2004/toc04.htm

ADHS. Cancer in Arizona; Cancer Incidence and Mortality, 1999-2001. Arizona Department of Health Services. State of Arizona. July 2005. Available at http://www.azdhs.gov/phs/phstats/acr/index.htm .

NCI. National Cancer Institute Fact Sheet-Cancer Health Disparities: Fact Sheet. National Cancer Institute. National Institutes of Health. United States Department of Health and Human Services. Posted April 2002. Updated November 2005. Available at http://www.cancer.gov/cancertopics/factsheet/cancerhealthdisparities .

NCI. National Cancer Institute Fact Sheet-Staging: Questions and Answers. National Cancer Institute. National Institutes of Health. United States Department of Health and Human Services. Reviewed January 2004. Available at http://www.cancer.gov/cancertopics/factsheet/Detection/staging .

ADHS. Comprehensive Cancer Control program website available at http://www.azcancercontrol.gov .

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Cancer Registry Review

This document is published by the Arizona Department of Health Services, Bureau of Public Health Statistics, Office of Health Registries, Arizona Cancer Registry. It is intended to provide information and education for those who read it.

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